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Report to California Legislature

Title

Analysis of California Assembly Bill 78: Health: Actuarial Value

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Author

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Analysis of California Assembly Bill 78

Health: Actuarial Value

Summary to the 2019-2020 California State Legislature, August 5, 2019



AT A GLANCE

The section of California Assembly Bill (AB) 78 analyzed by CHBRP includes language that would change the actuarial value (AV) requirements for bronze high-deductible health plans (HDHPs). AV measures the expected average amount spent on health care services by a plan or policy on behalf of all enrollees. For example, a plan or policy with an AV of 80% is expected to pay on average 80% of all health care expenditures, and the enrollee will pay the other 20% in the form of enrollee out-of-pocket expenses that include deductibles, copays, and/or coinsurance. In California, bronze HDHP plans and policies must have AVs no higher than 62%, a requirement referred to in this analysis as “the AV 62 limit.” The AV 62 limit is low enough that, unless the Internal Revenue Service (IRS) rules are changed, CHBRP is unaware of any way for a bronze plan to meet the IRS definition of a qualified HDHP in 2020, which allows an enrollee to use a health savings account (HSA). HSAs allow enrollees in HDHP plans or policies to use pre-tax dollars to pay for premiums and enrollee expenses. AB 78 would increase the upper limit of the AV range to 64%, making it possible for bronze HDHP plans to continue in California — and thus for enrollees in bronze HDHPs to continue to use HSAs.

If AB 78 is not enacted, CHBRP estimates that, in 2020, of the 24 million Californians enrolled in state-regulated health insurance, 246,000 will be enrolled in bronze HDHPs that will be affected by the AV 62 limit.

1. **Number of Uninsured in California.** Should AB 78 not be enacted, as a result of the AV 62 limit ending HSA-qualified bronze HDHPs, CHBRP would expect approximately 54,000 Californians who had been enrolled in Individual Market plans or policies to become uninsured. Although bronze HDHP and non-HDHP plans and policies can have very similar premiums and very similar enrollee expenses (deductibles, copays, etc.), which would allow many persons to switch from a bronze HDHP to a somewhat similar bronze non-HDHP, the absence of the option to use an HSA account would be likely to increase the number of uninsured. HSAs (instruments that are available to anyone covered by an HDHP plan or policy) can be funded with pre-tax dollars, effectively making premiums and enrollee expense more affordable, and may (by reducing taxable income) qualify a person for premium subsidies if purchasing a plan or policy through Covered California. Other instruments can be used by small group market enrollees, but individual market enrollees have access only to HSAs — and only when enrolled in an HSA-qualified HDHP plan or policy. The continuation of the AV 62 limit, which would end HSA-qualified bronze HDHPs, would be expected to make the choice of remaining insured less desirable for some Californians currently enrolled in individual market HSA-qualified bronze plans or policies.
2. **Benefit coverage.** Should AB 78 not be enacted, the AV 62 limit would make no measurable change in benefit coverage for persons who retain health insurance. However, persons who become uninsured due to the absence of HSA-qualified bronze HDHPs (this absence required by the AV 62 limit) would have no benefit coverage.
3. **Utilization and expenditures.** Should AB 78 not be enacted, the AV 62 limit would make no measurable change in per person utilization or expenditures for persons who retain health insurance. The AV 62 limit would decrease total utilization, as well as total premiums and total enrollee expenses, due the increase of uninsured persons - and the newly uninsured would have to pay the full cost of any services they do utilize.

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)¹ conduct an evidence-based assessment of AB 78. AB 78 includes language that would alter actuarial value (AV) rules for small-group and individual market bronze high-deductible health plans (HDHPs).

BILL SUMMARY

AB 78 would change the AV requirements for bronze HDHPs. Currently, in California such plans must have AVs that fall within the range of 58% to 62%,² a requirement referred to in this analysis as “the AV 62 limit.” The AV 62 limit is low enough that CHBRP is unaware of any way for a bronze plan to meet the IRS definition of a qualified HDHP in 2020.³ Therefore, in 2020, although other bronze plans and policies will continue to be present, bronze HDHPs will cease to be available in California unless the upper end of the AV range is increased, or the IRS rules are changed. AB 78 would increase the upper limit of the AV range, changing the allowable range from 58-62% to 58-64%, making it possible for bronze HDHP plans to continue existing in California.

The language of AB 78 that relates to actuarial value of bronze HDHPs can be found in Appendix A.

CONTEXT

As background, the following definitions might be helpful:

- **Actuarial value (AV).** AV measures the expected average amount spent by a plan or policy on behalf of all enrollees. It is calculated as the expected percentage of health care expenditures that will be paid by the health plan or insurer for all enrollees in the health plan. For example, a plan or policy with an AV of 80% is expected to pay on average 80% of all health care expenditures, and the enrollee will pay the other 20% in the form of deductibles, copays, and/or coinsurance.⁴
- **High-deductible health plan (HDHP).** An HDHP is a plan or policy with a deductible that is relatively high. The deductible must be fully satisfied and must apply to all services — except preventive care — before any benefits can be paid. The IRS defines the minimum allowable deductible, and a maximum allowable limit on out-of-pocket (OOP) expenses. For example, in 2019, an HDHP covering a single enrollee must have a deductible of at least \$1,350 and an OOP maximum of no more than \$6,750.⁵
- **Health savings account (HSA).** An HSA is a tax-exempt trust or custodial account that is owned by anyone and can be used to pay or reimburse most medical expenses. To qualify for an HSA, a person must be enrolled in an HDHP. Therefore, for a bronze enrollee to have an HSA, their bronze plan or policy must be an HDHP. If a plan or policy is not an HDHP, then the enrollee cannot have an HSA.
- **Health reimbursement account (HRA).** An HRA is an account established, funded, and owned by an employer, for the benefit of an employee. Employees cannot make contributions to the HRA. The funds are used to reimburse the employee for qualified health care expenses. Employees do not pay tax on the reimbursements. Having an HRA does not require having a HDHP.
- **Flexible spending account (FSA).** A health FSA is established by an employer to pay for an employee’s qualified health care expenses. Contributions to the FSA can be made by both the employer and the employee. Employee contributions can be made on a pre-tax basis. Employees do not pay tax on the reimbursements. Having an FSA does not require having a HDHP.

As will be explained below, HSAs are key to understanding the impact of the AV 62 limit. Among the three types of accounts described above (HSA, HRA, and FSA), the HSA is the only one that can be established for someone having individual insurance. The other two can only be established by an employer, and they do not require having an HDHP.

¹ CHBRP’s authorizing statute is available at <http://chbrp.org/faqs.php>.

² <https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1367-008.html>

³ Requirements for a plan to be a qualified HDHP are on the IRS website: <https://www.irs.gov/publications/p969>

⁴ More information on AVs is here:

http://chbrp.com/document_center/Analysis%20Methodology/Benefit%20Mandates%20and%20Actuarial%20Value%20FINAL.pdf

⁵ <https://www.irs.gov/publications/p969>

Current Actuarial Value Requirements

Effective for benefit plan year 2014, the Affordable Care Act (ACA) required that all small group and individual health insurance policies issued in 2014 or later must satisfy specified AV requirements, which are associated with “metal levels.” The ACA defined the metal levels and AV requirements as follows.:

- Platinum plans must have AVs of 88% to 92%
- Gold plans must have AVs of 78% to 82%
- Silver plans must have AVs of 68% to 72%
- Bronze plans must have AVs of 58% to 62%
- Catastrophic plans do not have AV requirements

California codified these AV requirements in Health and Safety Code paragraph 1367.008 and they have not been changed since 2014.

The U.S. Department of Health and Human Services (DHHS), effective for benefit plans year 2018, released a rule that allowed states to change the allowable AV ranges from those listed above to the following.⁶

- Platinum plans must have AVs of 86% to 92%
- Gold plans must have AVs of 76% to 82%
- Silver plans must have AVs of 66% to 72%
- Bronze plans must have AVs of 56% to 62%, or they may have AVs of 56% to 65% if either of the following conditions are met:
 - The bronze plan is an HDHP
 - The bronze plan pays for at least one major service — excluding preventive services — before the deductible applies

Most (if not all) other states adopted these expanded AV ranges.^{7,8} California, however, did not. Therefore, in California, the AVs of all bronze plans must still be in the range of 58% to 62%.

Compliance with the AV requirements must be tested using the federal AV Calculator, which is updated annually and published by HHS. It requires users to input key elements of an insurance plan’s cost-sharing amounts (e.g., the plan deductible, coinsurance rate, copays for various services, and the maximum limit for OOP expenses). Given those inputs, it calculates the plan’s AV. Plans having higher cost-sharing amounts have lower AVs. Bronze plans tend to have high deductibles and high OOP maximums, and thus low AVs. For example, in 2019, Covered California offers two bronze plans. While both plans have high deductibles, one qualifies as an HDHP and one does not. The deductible for a single enrollee on the HDHP plan is \$6,000, which applies to both medical services and prescription drugs. The non-HDHP plan has separate deductibles for medical and drugs, at \$6,300 and \$500, respectively, or \$6,800 in total.⁹ In 2020, the bronze HDHP plan deductible is proposed to increase to \$6,950, and no changes are proposed to deductibles on the bronze non-HDHP plan.¹⁰

⁶ <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/revised-final-2018-av-methodology-41317.pdf>

⁷ The federal AV calculator and instructions are available on the HHS website: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/>

⁸ Personal communication, J. Bertko, March 2019.

⁹ Covered California. Covered California 2019 Patient-Centered Benefit Plan Designs. 2018. Available at: <https://hbex.coveredca.com/stakeholders/plan-management/PDFs/FINAL-2019-Patient-Centered-Benefit-Plan-Designs-2018-03-15-Clean.pdf>. Accessed March 2019.

¹⁰ <https://hbex.coveredca.com/stakeholders/plan-management/library/Proposed-2020-Plan-Designs-Side-by-Side-Comparison-2019-03-14.pdf>

Limits on Out-of-pocket Expenses

The ACA placed limits on how high OOP maximums can be. The limits are increased annually according to an inflation index, and published by HHS. For example, the limit for a single person is \$7,900 in 2019, and is currently proposed to increase to \$8,200 in 2020.

HDHPs are also constrained by limits on their cost-sharing levels. To qualify as an HDHP, the deductible must be at least as high as a specified threshold, and the OOP maximum cannot be above a separate threshold. For example, for a person enrolled with self-only coverage in 2019, the deductible must be at least \$1,350 and the OOP maximum must be no more than \$6,750.¹¹ The limits for 2020 have not yet been published. However, based on past annual updates, the OOP limit is expected to increase by approximately \$100, to \$6,850. The deductible proposed by Covered California for their bronze HDHP plan in 2020 is \$6,950, which would exceed the limit for qualified HDHP plans, and thus the plan would no longer be an HDHP. The HDHP OOP limit differs from the OOP limit specified by HHS because the two limits are calculated according to different methodologies.

Bronze HDHP Plans in 2020

In 2020, in California, CHBRP is unaware of a benefit plan that will satisfy both the AV requirements to be a bronze plan, and the OOP limit requirements to be an HDHP. Therefore, it is expected that no bronze HDHP plans or policies will be available (though non-HDHP bronze plans and policies will still exist). This conundrum has been broadly recognized by industry experts, which is partly why other states have increased their bronze plan limits to as high as 65%.¹²

POPULATION AFFECTED

The AV 62 limit is only applicable to the health insurance of bronze enrollees in nongrandfathered small-group and individual plans and policies, both on- and off-exchange. It applies to plans and policies regulated by both the California Department of Managed Care (DMHC) and the California Department of Insurance (CDI) and it applies to plans and policies on and off Covered California (the state's health insurance exchange). As shown in Table 1, in 2020, approximately 24.5 million (61.8% of all Californians) will be enrolled in health insurance regulated by DMHC or in health insurance regulated by CDI. As shown in Tables 2 and 3, approximately 950,000 (2.4% of Californians) will be enrolled in HDHP or non-HDHP bronze plans or policies. In this group, approximately 246,000 are enrolled in bronze HDHPs.¹³

IMPACTS

If AB 78 is not implemented, the AV 62 limit will have no measureable impact on benefit coverage and expenses for persons who remain insured. However, due to the lack of HSA-qualified bronze HDHP plans and policies, CHBRP would expect some Californians currently enrolled in individual market plans and policies to become uninsured in 2020.

Number of Uninsured in California

If AB 78 is not implemented and the AV 62 limit remains in effect, the AV 62 limit will result in bronze HDHP plans and policies no longer being available in California in 2020. For this analysis, CHBRP has assumed that people who would have been enrolled in bronze HDHP plans either will switch to a non-HDHP bronze plan, or will become uninsured. The

¹¹ <https://www.irs.gov/publications/p969>

¹² Personal communication, J. Bertko, March 2019.

¹³ Data provided by Covered California indicated that approximately 26% of Covered California's bronze enrollees are in HDHPs. For this analysis, CHBRP has assumed that the same percentage would apply to individual and small group bronze enrollees issued outside of the exchange.

number of uninsured people in California would be expected to increase by approximately 54,000 — all of those people having been previously enrolled in individual market bronze HDHP plans or policies.

For this analysis, CHBRP assumed that 100% of enrollees in small-group bronze HDHPs will switch into other bronze plans/policies, as their employers will continue to secure comparable health insurance coverage. Employers in the small-group market have other options through which their employees can fund health care out-of-pocket expenses on a tax advantaged basis, such as making available a health reimbursement account (HRA) or a flexible spending account (FSA).

CHBRP has assumed that enrollees in individual market bronze HDHPs will be more sensitive to the loss of HDHP qualification because HRAs and FSAs are not available to them (those instruments are only available to employers). Additionally, these individual market enrollees are more likely to have chosen a bronze HDHP based on evaluation of their own unique financial situation. They may be funding an HSA (instruments that are available to anyone covered by an HDHP plan or policy) with pre-tax dollars, effectively making premiums and enrollee expense more affordable, as well as by reducing taxable income, making it more likely for the person to qualify for premium subsidies if they purchase a plan or policy offered on Covered California. In such circumstances, the continuation of the AV 62 limit may make the choice of remaining insured less desirable for some people. For this analysis, CHBRP has assumed that two out of every three of these enrollees would switch into another bronze plan/policy and that the other one-third of enrollee would become uninsured.¹⁴

For these reasons, in 2020, CHBRP would expect that most enrollees in small-group market bronze HDHP plans and policies will switch to non-HDHP bronze plans. However, if AB 78 is not implemented and the AV 62 limit remains in effect, then approximately 54,000 persons who would have been enrollees in individual market bronze HDHPs, many of them using the HSAs that are only allowed with a HDHP, will become uninsured.

Premium rates and out-of-pocket expenses per enrollee are sufficiently similar in HDHP and non-HDHP plans that CHBRP did not model the impacts of enrollment changes on the average amounts per enrollee. Some HDHP plan/policy premiums are higher than premiums for non-HDHP plans/policies, but some are less.

Table 1 (at the end of this section) shows projected changes if AB 78 is not implemented and the AV 62 limit is in effect in 2020. Tables 2 and 3 note expected impacts specific to market segments if the AV 62 limit remains in place. The changes in total expenditures, as shown in Table 1, occur only because one-third of the individual market bronze HDHP enrollees are assumed to become uninsured if the AV 62 limit continues.

Benefit Coverage

No measurable change in benefit coverage is expected for persons who retain health insurance. Persons who become uninsured would have no benefit coverage.

Utilization

If AB 78 is not implemented and the AV 62 limit remains in effect, no measurable change in the per person utilization of healthcare tests, treatments, or services is expected for enrollees who remain insured. Enrollees who become uninsured would be expected to use less, as they would have to pay the full cost of any tests, treatments, or services.

¹⁴ If the AV 62 limit continues, the percentage of bronze HDHP members who become uninsured will also depend on whether California reinstitutes tax penalties for people who do not have health insurance coverage (i.e., the individual mandate). The California legislature is currently considering whether to reinstitute that mandate. If it is reinstituted, then the actual percentage of bronze HDHP enrollees who become uninsured might be lower than CHBRP has assumed for this analysis.

Expenditures

CHBRP projects no measurable impact on per person health care expenditures (premiums and enrollee expenses) for enrollees who remain insured. Enrollees who become uninsured would be expected to have lowered expenditures, as they would have to pay the full cost of any tests, treatments, or services. As noted in Table 2, bronze HDHP and non-HDHP plans and policies can have very similar premiums and very similar enrollee expenses (deductibles, copays, and/or coinsurance). It is not an impact on premiums or enrollee expenses that would increase the number of uninsured. As already noted, it is the absence of the option to use an HSA account that would be likely to increase the number of uninsured.

If AB 78 is not implemented and the AV 62 limit remains in effect, total health care expenditures for people enrolled in plans and policies regulated by DMHC and CDI will decrease, due to some currently insured people becoming uninsured. The projected expenditure decline is approximately \$362 million (0.23%) in 2020, as shown in Table 1.

Medi-Cal

As no Medi-Cal beneficiaries are enrolled in small-group or individual market bronze HDHP plans, there would be no impact on Medi-Cal regardless of whether AB 78 is implemented.

CalPERS

As no CalPERS beneficiaries are enrolled in small-group or individual market bronze HDHP plans, there would be no impact on CalPERS regardless of whether AB 78 is implemented.

Essential Health Benefits and the Affordable Care Act

AB 78 will not change the scope of services that health plans are required to cover. Therefore, AB 78 would not interact with Essential Health Benefits (EHBs).

Table 1. Impacts of AV 62 Limit on Benefit Coverage, Utilization, and Cost, 2020

	Baseline	Without AB/SB ## AV Limit	Increase/Decrease	Percentage Change
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	24,490,000	24,436,222	-53,778	-0.22%
Total enrollees with health insurance subject to AB 78	24,490,000	24,436,222	-53,778	-0.22%
Total enrollees in small-group market bronze HDPDs	85,014	0	-85,014	-100.00%
Total enrollees in other small-group market bronze	241,963	326,977	85,014	35.14%
Total enrollees in individual market bronze HDHPs	161,333	0	-161,333	-100.00%
Total enrollees in other individual market bronze	459,178	566,733	107,555	23.42%
Expenditures				
<u>Premiums by payer</u>				
Private employers for group insurance	\$86,438,375,000	\$86,438,375,000	\$0	0.00%
CalPERS HMO employer expenditures (c) (b)	\$3,098,551,000	\$3,098,551,000	\$0	0.00%
Medi-Cal Managed Care Plan expenditures	\$28,492,273,000	\$28,492,273,000	\$0	0.00%
Enrollees with individually purchased insurance	\$12,045,324,000	\$11,816,055,121	-\$229,268,879	-1.90%
Individually Purchased – Outside Exchange	\$2,486,222,000	\$2,441,893,806	-\$44,328,194	-1.78%
Individually Purchased – Inside Exchange	\$9,559,102,000	\$9,374,161,316	-\$184,940,684	-1.93%
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c)	\$14,476,394,000	\$14,476,394,000	\$0	0.00%

Enrollee expenses				
For covered benefits (deductibles, copayments, etc.)	\$14,750,880,000	\$14,617,887,005	-\$132,992,995	-0.90%
For noncovered benefits (d) (e)	\$0	\$0	\$0	0.00%
Total expenditures	\$159,301,797,000	\$158,939,535,126	-\$362,261,874	-0.23%

Source: California Health Benefits Review Program, 2019.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.¹⁵

(b) Approximately 56.17% of CalPERS enrollees in DMHC-regulated plans are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC.¹⁶

(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(e) Although enrollees who remain insured would see no measurable change in expenses for noncovered benefits, enrollees who become uninsured would have to pay for all of their health care expenditures.

¹⁵ For more detail, see *Estimates of Sources of Health Insurance in California*, available at http://chbrp.com/analysis_methodology/cost_impact_analysis.php.

¹⁶ For more detail, see *Estimates of Pharmacy Benefit Coverage*, available at http://chbrp.com/analysis_methodology/cost_impact_analysis.php.

Table 2. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2020

	DMHC-Regulated				CDI-Regulated				Total
	<i>Small Group Bronze HDPD</i>	<i>Small Group other Bronze</i>	<i>Individual Bronze HDPD</i>	<i>Individual other Bronze</i>	<i>Small Group Bronze HDPD</i>	<i>Small Group other Bronze</i>	<i>Individual Bronze HDPD</i>	<i>Individual other Bronze</i>	
Enrollee counts									
Total enrollees in plans/policies subject to state mandates (a)	79,454	226,137	148,247	421,934	5,560	15,826	13,086	37,243	947,487
Total enrollees in plans/policies subject to AB 78	79,454	226,137	148,247	421,934	5,560	15,826	13,086	37,243	947,487
Premiums									
Average portion of premium paid by employer	\$262.42	\$262.42	\$0.00	\$0.00	\$373.24	\$373.24	\$0.00	\$0.00	\$93.06
Average portion of premium paid by employee	\$157.64	\$157.64	\$348.44	\$348.44	\$163.41	\$163.41	\$432.72	\$432.72	\$287.20
Total premium	\$420.06	\$420.06	\$348.44	\$348.44	\$536.66	\$536.66	\$432.72	\$432.72	\$380.26
Enrollee expenses									
For covered benefits (deductibles, copays, etc.)	\$248.19	\$248.19	\$203.27	\$203.27	\$311.24	\$311.24	\$237.92	\$237.92	\$222.04
For noncovered benefits (b)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total expenditures	\$248.19	\$248.19	\$203.27	\$203.27	\$311.24	\$311.24	\$237.92	\$237.92	\$222.04

Source: California Health Benefits Review Program, 2019.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care

Table 3. Impacts of the Mandate on Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2020

	DMHC-Regulated				CDI-Regulated				Total
	Small Group Bronze HDPD	Small Group other Bronze	Individual Bronze HDPD	Individual other Bronze	Small Group Bronze HDPD	Small Group other Bronze	Individual Bronze HDPD	Individual other Bronze	
Enrollee counts, if AV 62 Limit Continues									
Total enrollees in plans/policies subject to state mandates (a)	0	305,591	0	520,765	0	21,386	0	45,967	893,709
Total enrollees in plans/policies subject to AB 78	0	305,591	0	520,765	0	21,386	0	45,967	893,709
Premiums	For those who remain insured, no measureable change is expected.				For those who remain insured, no measureable change is expected.				
Enrollee expenses (b)	For those who remain insured, no measureable change is expected.				For those who remain insured, no measureable change is expected.				

Source: California Health Benefits Review Program, 2019.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Includes only those expenses that are paid directly by enrollees or other sources to providers for services related to the mandated benefit that are not currently covered by insurance. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care

APPENDIX A TEXT OF BILL ANALYZED

The California Assembly Committee on Health requested that CHBRP analyze AB 78 language that would alter California statutes that establish actuarial value for nongrandfathered bronze high deductible health plans and policies. Following is the relevant language from AB 78,

AMENDED IN SENATE JUNE 18, 2019

CALIFORNIA LEGISLATURE— 2019–2020 REGULAR SESSION

ASSEMBLY BILL

NO. 78

Introduced by ~~Assembly Member Ting~~ Committee on Budget (Assembly Members Ting (Chair), Arambula, Bloom, Chiu, Cooper, Frazier, Cristina Garcia, Jones-Sawyer, Limón, McCarty, Medina, Mullin, Muratsuchi, Nazarian, O'Donnell, Ramos, Reyes, Luz Rivas, Blanca Rubio, Mark Stone, Weber, Wicks, and Wood)

December 03, 2018

~~An act relating to the Budget Act of 2019.~~ An act ...to add Sections ... 1367.0085, ...of the the Health and Safety Code... and to add Section 10112.296 to the Insurance Code...

LEGISLATIVE COUNSEL'S DIGEST

AB 78, as amended, Committee on Budget. ~~Budget Act of 2019.~~ Health.

(14) Existing federal law, the PPACA, established annual limits on deductibles and defining bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, which provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime, and similar provisions of the Insurance Code, which provide for the regulation of health insurers by the Department of Insurance, prohibit the actuarial value for a nongrandfathered individual or small employer health plan or health insurance policy from varying by more than plus or minus 2%. This bill would instead authorize the actuarial value for a nongrandfathered bronze level high deductible health plan or health insurance policy to range from plus 4% to minus 2%. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SEC. 16.

Section 1367.0085 is added to the Health and Safety Code, to read:

1367.0085.

Notwithstanding paragraph (1) of subdivision (b) of Section 1367.008 and paragraph (1) of subdivision (b) of Section 1367.009, the actuarial value for a nongrandfathered bronze level high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 4 percent to minus 2 percent.

SEC. 29.

Section 10112.296 is added to the Insurance Code, to read:

10112.296.

Notwithstanding paragraph (1) of subdivision (b) of Section 10112.295 and paragraph (1) of subdivision (b) of Section 10112.297, the actuarial value for a nongrandfathered bronze level high deductible health insurance policy that is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 4 percent to minus 2 percent.

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

Faculty Task Force

Janet Coffman, MA, MPP, PhD, *Vice Chair for Medical Effectiveness*, University of California, San Francisco
Gerald Kominski, PhD, University of California, Los Angeles
Sara McMenamin, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, San Diego
Joy Melnikow, MD, MPH, *Vice Chair for Public Health*, University of California, Davis
Jack Needleman, PhD, University of California, Los Angeles
Ninez Ponce, PhD, University of California, Los Angeles
Nadereh Pourat, PhD, *Vice Chair for Cost*, University of California, Los Angeles
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Marilyn Stebbins, PharmD, University of California, San Francisco

Task Force Contributors

Danielle Casteel, MA, University of California, San Diego
Shana Charles, PhD, MPP, University of California, Los Angeles,
 and California State University, Fullerton
Shauna Durbin, MPH, University of California, Davis
Margaret Fix, MPH, University of California, San Francisco
Sarah Hiller, MA, University of California, San Diego
Naomi Hillery, MPH, University of California, San Diego
Jeffrey Hoch, PhD, University of California, Davis
Michelle Ko, MD, PhD, University of California, Davis
Kevin Lee, PhD Candidate, University of California, Berkeley
Elizabeth Magnan, MD, PhD, University of California, Davis
Ying-Ying Meng, PhD, University of California, Los Angeles
Jacqueline Miller, University of California, San Francisco
Dominique Ritley, MPH, University of California, Davis
Dylan Roby, PhD, University of California, Los Angeles, and
 University of Maryland, College Park
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego
Christopher Toretsky, MPH, University of California, San Francisco
Ed Yelin, PhD, Professor Emeritus, University of California, San Francisco

Sara Yoeun, University of California, San Diego

National Advisory Council

Lauren LeRoy, PhD, Strategic Advisor, L. LeRoy Strategies, *Chair*

Stuart H. Altman, PhD, Professor of National Health Policy, Brandeis University, Waltham, MA

Deborah Chollet, PhD, Senior Fellow, Mathematica Policy Research, Washington, DC

Allen D. Feezor, Fmr. Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, Raleigh, NC

Charles “Chip” Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC

Jeffrey Lerner, PhD, President and CEO, ECRI Institute Headquarters, Plymouth Meeting, PA

Donald E. Metz, Executive Editor, *Health Affairs*, Bethesda, MD

Dolores Mitchell, (Retired) Executive Director, Group Insurance Commission, Boston, MA

Marilyn Moon, PhD, Vice President and Director, Health Program, American Institutes for Research, Silver Spring, MD

Carolyn Pare, President and CEO, Minnesota Health Action Group, Bloomington, MN

Richard Roberts, MD, JD, Professor of Family Medicine, University of Wisconsin-Madison, Madison, WI

Alan Weil, JD, MPP, Editor-in-Chief, *Health Affairs*, Bethesda, MD

CHBRP Staff

Garen Corbett, MS, Director

John Lewis, MPA, Associate Director

Adara Citron, MPH, Principal Policy Analyst

Karen Shore, Contractor*

Ana Ashby, Health Policy Graduate Assistant

California Health Benefits Review Program

MC 3116

Berkeley, CA 94720-3116

info@chbrp.org

www.chbrp.org

(510) 664-5306

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Bruce Abbott, MLS, of the University of California, conducted the literature search. Chris Girod, FSA, MAAA, of Milliman, prepared the cost impact analysis. John Lewis, MPA, of CHBRP staff prepared the Policy Context and synthesized the individual sections into a single report. A member of the CHBRP Faculty Task Force, Ed Yellin, PhD, of the University of California, San Francisco, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

Garen Corbett, MS
Director

Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org.